TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Orthopedic Hospital

Respondent Name
Indemnity Insurance Co of North America

MFDR Tracking Number
M4-17-0176-01

Carrier's Austin Representative
Box Number 15

MFDR Date Received
September 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "… it is the position of the Hospital that all charges relating to the admission of this claimant are due and payable and not subject to the improper reductions taken by the Carrier in this case."

Amount in Dispute: $2,143.60

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Subject to further review, the carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 14, 2015	Outpatient hospital services	$2,143.60	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers compensation jurisdictional fee schedule adjustment

- 18 – Duplicate claim/service
- W3 – Request for reconsideration
- 59 – Processed based on multiple or concurrent procedure rules
- 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement for $2,143.60 for outpatient hospital services rendered on December 14, 2015.

   The insurance carrier reduced the disputed services with reduction codes, P12 – "Workers compensation jurisdictional fee schedule adjustment," 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated" and 59 – "Processed based on multiple or concurrent procedure rules."

   The Division finds that the outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

2. The applicable Medicare payment policy is located at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

   - **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

- **Multiple procedure discounts -** Multiple surgical procedures furnished during the same operative session are discounted. The full amount is paid for the surgical procedure with the highest weight; Fifty percent is paid for any other surgical procedure(s) performed at the same time;

28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
>
> (A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Multiple Procedure Discounts Apply	Status Indicator	Payment Rate	60% labor related	2015 Wage Index Adjustment for provider 0.9679	40% non-labor related	Payment Calculation	Maximum allowable reimbursement
29891	0042	No	T	$4,345.55	$4,345.55x 60% = $2,607.33	$2,607.33 x 0.9679 = $2,523.63	$4,345.55 x 40% = $1,738.22	$2,523.63 + $1,738.22 = $4,261.85	$4,261.85 x 200% = $8,523.70
29898	0041	Yes	T	$2,151.57 x 50% = $1,075.79	$1,075.79 x 60% = $645.47	$645.47 x 0.9679 = $624.75	$1,075.79 x 40% = $430.32	$624.75 + $430.32 = $1,055.07	$1,055.07 x 200% = $2,110.14
								Total	$10,633.84

The submitted procedure code 97001 – "Physical therapy evaluation," has status indicator A denoting services paid under a fee schedule or payment system other than OPPS.

Per 28 Texas Administrative Code §134.403(h) states,

> For medical services provided in an outpatient acute care hospital, but not addressed in the Medicare payment policies as outlined in subsections (f)(1) or (f)(2) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided.

The Medicare fee schedule for physical therapy is calculated according to the Medical Fee Guideline for Professional Services, §134.203(c) which states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The reimbursement rate is calculated as follows;

(DWC Conversion Factor / Medicare Conversion Factor) x Medicare allowable = Texas Fee or

56.2/35.9335 x $76.76 = $120.05

The remaining services classifications are:

- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2704 has status indicator N denoting packaged items and services with no separate APC payment.
- Per National Correct Coding Initiative (CCI) edits, procedure code 29895 may not be reported with procedure code 29898 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment not recommended.
- Procedure code G8980 has status indicator E denoting non-covered items, codes or services not paid by Medicare when submitted on outpatient claims. Reimbursement not recommended.
- Procedure code G8979 has status indicator E denoting non-covered items, codes or services not paid by Medicare when submitted on outpatient claims. Reimbursement not recommended.
- Procedure code G8978 has status indicator E denoting non-covered items, codes or services not paid by Medicare when submitted on outpatient claims. Reimbursement not recommended.
- Procedure code J0690 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.

3. The total allowable reimbursement for the services in dispute is $10,753.89. This amount less the amount previously paid by the insurance carrier of $10,753.90 leaves an amount due to the requestor of $0.00. No additional reimbursement recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 27, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.